MEDICAL RECORD	Extramural Request for Human Biological Materials For Research Purposes

PRINCIPAL INVESTIGATOR INFORMATION

Extramural Principal Investigator (print legibly)	Institution
Address	Phone: E-mail:

Billing Information for Recuts/Restains: _____

_____

(Reference Lab will bill requestor for work requiring recuts or restains)

Material will be shipped to above address unless otherwise specified. Indicate preferred shipping company and billing account number: _____

DESCRIPTION OF RESOURCE NEEDS

Tissue Source Requested:
- ☐ Normal Tissue
- ☐ Abnormal Tissue (indicate key diagnostic terminology for database search): _____

Recuts:
- ☐ Recuts Number of Slides: _____
- ☐ Pathology Review
- ☐ RNase Precautions
- ☐ Other (specify): _____

Tissue Type (check all that apply):
- ☐ Paraffin ☐ Cytology ☐ Autopsy
- ☐ Other (specify): _____

Recut Slide Type (check):
- ☐ Regular/Untreated ☐ Poly-L-Lysine
- ☐ Gelatin ☐ Silanated
- ☐ Other (specify): _____

NOTE: Materials cannot be released unless sufficient material is retained for clinical diagnostic purposes.

Patient Name	NIH Medical Record Number	Patient Date of Birth
NIH Attending Physician (if known)	Date of Surgery/Specimen Collection	NIH Block Number(s) (if known)
Title of Your Protocol:	Date of Current Approval by Your IRB	

Permission is hereby granted to the National Institutes of Health to release the materials requested herein and to obtain copies of pathology reports pertaining to the material to the individual/organization as identified above. (Note: submission of this form authorizes the release of materials and information specified within one year from date of signature.)

Patient (or Guardian) Signature _____ Date _____

CERTIFICATION BY EXTRAMURAL PRINCIPAL INVESTIGATOR

I certify that the research use of the requested human biological material will be in accordance with the IRB approved protocol and consent referenced above.

Signature of Extramural Principal Investigator _____ **Date** _____

APPROVAL BY INTRAMURAL PRINCIPAL INVESTIGATOR/CLINICAL DIRECTOR

☐ Approve ☐ Disapprove Date: _____

Signature: _____ Title: _____

FOR INTERNAL USE ONLY BY NCI, LABORATORY OF PATHOLOGY:

Date Received: _____ Outcome: _____ Signature: _____

Patient Identification	Extramural Request for Human Biological Materials For Research Purposes NIH-2803-2 (9-01) P.A. 09-25-0099 File in Section 4: Authorization